Indiana Medicaid Program

FY 1999 Annual Report

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July 1, 1998–June 30, 1999

The Honorable Frank O'Bannon
Governor of the State of Indiana
Indiana State House
Indianapolis, Indiana 46204

Dear Governor O'Bannon:

It is my pleasure to present to you an annual report for the Indiana Medicaid Program administered by the Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP). This report highlights the accomplishments and significant activities of OMPP for the 1999 state fiscal year (July 1, 1998 through June 30, 1999) and presents general information on the Indiana Medicaid Program.

In SFY 1999, Hoosier Healthwise eligibility was expanded to 150 percent of the federal poverty level for all children from age 0 through 18 as "Phase I" of Indiana's implementation of the federal Children's Health Insurance Program (CHIP). A simplified enrollment process and a comprehensive, community-based outreach effort resulted in dramatic increases for children throughout SFY 1999. Also, 100 more primary medical providers (PMPs) joined Hoosier Healthwise and 188 more dental providers enrolled in Medicaid.

In the long term care area, a new case mix reimbursement system for nursing facilities was implemented that better matches reimbursement to the care and resource needs of the residents. The Indiana Long Term Care Insurance Program experienced a large increase in the sale of "Partnership Policies." Sales increased from 872 in CY 1997, to 2,033 in CY 1998 and to 1,677 in just the first six month of CY 1999. Also in SFY 1999, the personal needs allowance for persons who reside in institutions was raised from $35 to $50 per month.

Finally, work continued throughout SFY 1999 to improve claims processing performance, to increase collections from Medicare and other third party payers, and to enhance efforts to monitor the appropriateness of payments in the Medicaid program.

On behalf of the entire OMPP staff, I want to thank you for your support of this important program, which provides vital health care services to so many Indiana citizens.

Sincerely,

Kathleen D. Gifford
Assistant Secretary
Office of Medicaid Policy and Planning

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FY 1999 Highlights

Increased Enrollment in Hoosier Healthwise

On July 1, 1998, Hoosier Healthwise eligibility was expanded to 150 percent of the federal poverty level for all children 0-18 years old as "Phase I" of Indiana's implementation of the federal Children's Health Insurance Program (CHIP). At the same time, the Office of Medicaid Policy and Planning (OMPP), the CHIP Office and the Division of Family and Children (DFC) worked closely together to implement sweeping changes to simplify enrollment and improve outreach. These changes included simplification of the application development of a mail-in application packet and processing unit, establishment of over 500 community enrollment centers and initiation of a marketing campaign. The results of these efforts not only enrolled additional children under CHIP-Phase I, but also enrolled children, pregnant women and low-income adults who were previously eligible for Medicaid but were not enrolled.

The table to the right lists the total enrollment of children, pregnant women, and low-income families in the Hoosier Healthwise managed care program at the beginning and the end of SFY 1999. The total number of members enrolled increased 42 percent during SFY 1999. With increasing member enrollment, the Hoosier Healthwise managed care program continues to enroll more doctors to be Hoosier Healthwise Primary Medical Providers (PMPs). Hoosier Healthwise added 100 PMPs throughout the State of Indiana in SFY 1999, resulting in PMPs enrolled in all 92 counties.

The Hoosier Healthwise Helpline (at 1-800-889-9949) call volume increased dramatically in SFY 1999 and peaked in March 1999 with a total of 31,477 calls. The average monthly Helpline call volume was 13,804 in SFY 1998 and 25,478 in SFY 1999, which is an 85 percent increase. In the fall of 1998, additional phone lines were installed and staff were added to handle the growing volume of calls. Also, due to program improvements, including education of members about physician choice, the default auto-assignment rate dropped 31 percent in SFY 1999 despite the growth in overall enrollment.

In 1999, Governor O'Bannon signed into law the second phase of CHIP, which began January 1, 2000. The second phase of CHIP, *called Hoosier Healthwise Package C - Children's Health Plan*, is a non-Medicaid expansion of Hoosier Healthwise and focuses on children in families with income levels between 150 and 200 percent of the federal poverty level. It was expected that up to 16,000 additional uninsured children would enroll in Package C by December 2000.

Dr. Whoosier, the Hoosier Healthwise mascot, and friends.

Changes in Hoosier Healthwise Managed Care Program-SFY 1999 [TABLE 1]

	July 98	June 99	% change
Total PMPs Enrolled	1,844	1,941	+5%
Total Members Enrollment	233,625	331,207	+42%
Total Helpline Calls	20,971	25,058	+19%
Default Auto-assignment	29%	9%	-31%

Improving Health Care Access

The OMPP and Indiana State Department of Health (ISDH) are working in partnership to improve access to health care service providers. These efforts contributed to the number of active Medicaid providers in Indiana reaching 20,239 in SFY 1999. Of

the 20,239 active Medicaid providers, 7,166 are primary care physicians.[1] During SFY 1999, 56 of the 92 counties increased their provider enrollment. The OMPP and ISDH will continue to work together to increase pediatric and dental provider access and improve vaccination and lead screening rates for Hoosier children.

In addition to OMPP's partnership with the ISDH, dramatic steps taken by OMPP in SFY 1998 and SFY 1999 have resulted in a significant increase in access to dental services within the Indiana Medicaid program. With assistance from the Indiana Dental Association, OMPP convened a Dental Advisory Panel composed of practicing dental providers from throughout the state. On May 1, 1998, OMPP implemented significant rate increases for dental services. In addition, effective August 1, 1998, dental services were removed from Risk Based Managed Care (RBMC). (See discussion of *Hoosier Healthwise Managed Care Program* for an explanation of terms). As a result, all dental claims are paid to dentists directly on a fee-for-service basis and Hoosier Healthwise Managed Care members have direct access to dental services.

The outcome of these efforts has been very positive. From June 1998 to June 1999, an additional 188 dental providers (13 percent increase) enrolled bringing the total enrolled in June 1999 to approximately 1,600. As the number of providers increased in SFY 1999, so did the number of recipients of dental services. There were 209,921 recipients of dental services in SFY 1999, which was a 57 percent increase from SFY 1998. The number of children receiving dental services also increased in SFY 1999. Fifty-eight percent more children received dental services in SFY 1999 compared to SFY 1998, with 119,548 children receiving care. Of the approximately 1,600 dentists enrolled as Medicaid providers, six percent are pediatric dentists.

Improvements in Claims Processing

Electronic Data Systems, Inc. (EDS), the claims processing contractor, intensely focused on identifying system edits that were inappropriately denying claims, and has implemented mechanisms to correct and reprocess affected claims. These system and policy changes have enhanced overall claims processing time. During June 1999, 95 percent of the 3,297,658 claims processed were paid within 30 days.

Average Claim Processing Time from Receipt to Payment (June 1999) [TABLE 2]

Claim Type	Processing Time (days)
Medical	13
Medical Crossovers	18
Institutional Crossovers	26
Dental	9
Pharmacy	7
Home Health	11
Inpatient	12
Long Term Care	7
Outpatient	11

Increase in Policies Purchased from Indiana Long Term Care Insurance Program

There has been a significant increase in purchases of long term care insurance policies. The Indiana Long Term Care Insurance Program, also known as the Indiana "Partnership Program," is a program administered by OMPP that encourages the sale and purchase of private long term care insurance by providing "Medicaid asset protection" to purchasers of qualifying policies. The program is a partnership among OMPP, the Indiana Department of Insurance and private long term care insurance companies. The number of policies sold increased from 872 policies in calendar year 1997, to 2,033 in calendar year 1998. From January to June 1999 there were 1,677 policies purchased. The Indiana Long Term Care Program also had its first employer-group sales during SFY 1999. This accounted for 128 certificates being sold to persons in the age range of 25 to 63 years.

At the end of SFY 1999, the Indiana Long Term Care Program conducted a direct mail campaign, mailing an informational piece to over 302,000 Hoosiers ages 55 to 75 who have household incomes of $25,000 or more annually. There were 7,971 re-

[1]*Primary care physicians are defined as health care providers specializing in General Practice, Family Practice, General Pediatrics, General Internal Medicine, or Obstetrics/Gynecology.*

sponses to the direct mail campaign, a majority by returning the response cards. Responses were also received by telephone, e-mail and posting addresses on the Indiana Long Term Care Program website. Approximately 100 additional inquiries come in each month.

Medical Policy and Surveillance and Utilization Review Functions Transitioned to Health Care Excel

In SFY 1999 OMPP transitioned the medical policy function and the surveillance and utilization review function from the former contractor, EDS, to a new and nationally-recognized vendor, Health Care Excel (HCE). HCE assumed day-to-day operational responsibility for these functions on January 1, 1999.

"Medical Policy" entails the research, review, and development of service coverage parameters and related criteria. This core program function essentially sets the guidelines by which Indiana Medicaid operates; clear and objective medical policy is essential for the smooth and efficient operation of the program. Initial work performed by HCE included an in-depth review of services requiring prior authorization. The outcome of the review was a recommendation, subsequently adopted and implemented by OMPP, that some covered services be deleted from prior authorization status. The 137 services that were ultimately deleted from prior authorization are being retrospectively monitored to ensure appropriateness of utilization. In addition, HCE will continue to periodically assess prior authorization activity to determine whether or not removal of additional services from prior authorization is warranted.

The Surveillance and Utilization Review Unit (SUR) safeguards against unnecessary care and services and ensures that payments are appropriate according to the policies established by Indiana Medicaid relative to coverage, reimbursement and billing. Since the transition of this function to HCE in January 1999, the following goals have been accomplished:

- ✓ Development of an automated case tracking and reporting system for SUR operations.
- ✓ Reduction in the number of pending SUR appeals from 94 open cases to 23 as of June 30, 1999.
- ✓ 100 percent compliance with contract requirements for telephones during first six months of operations.
- ✓ Identification of 56 new members for placement in the Restricted Card Program.

Smoking Cessation Benefit Added

Smoking has proved to be a major contributor to disease and premature death. There is overwhelming evidence that smoking cessation is an important and readily available modality to prevent disease and disability and arrest smoking-related disease processes. In recognition of both the need and availability of treatment to facilitate smoking cessation, the Indiana Medicaid Program began providing reimbursement for these services in October 1999.

Decrease in Chiropractic Expenditures

The SFY 1998 Annual Report included details of an ongoing administrative and criminal fraud investigation by the SUR Unit and Indiana Medicaid Fraud Control Unit (IMFCU) of five chiropractors in the Northern District of Indiana. The five chiropractors in question had received Medicaid reimbursements totaling over $5 million since 1996. The SUR unit placed 18 chiropractors on pre-payment review status as the criminal and civil proceedings continued. Additional review and changes in medical policy and provider education were completed. Efforts to reduce inappropriate expenditures continued in this area, and more providers were placed on pre-payment review. As a result of the combined efforts of IMFCU, OMPP and the SUR unit, expenditures have declined from a high of $1,080,287 in March 1998 to an average monthly expenditure for SFY 1999 of $202,970. In the fourth quarter of SFY 1999, the IMFCU collected $800,000 in restitution from one of the providers involved in this investigation.

Overview of the Indiana Medicaid Program

Medicaid is a health care program for low-income individuals that is jointly financed by the state and federal governments. Each state administers its own program within broad federal guidelines. Thus, state programs vary in eligibility criteria, services covered, limitations on services and reimbursement levels. In Indiana, Medicaid is administered by the Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP). During state fiscal year 1999, the federal financial share of Indiana's Medicaid program was approximately 61.1 percent, while the state's share was about 38.9 percent.

Who is Covered by Indiana Medicaid?

Medicaid was created to provide health care to certain low-income individuals. State Medicaid programs are required by the federal government to cover certain groups, while other groups are covered at the option of the state. To be eligible for Medicaid, a person must belong to one of the groups described below and meet certain financial criteria. The Medicaid Eligibility Overview Table on page 8 lists the specific criteria for each eligibility category that a person must meet to become eligible for Medicaid.

Members of Families with Children Families meeting the income and resource standards for the Temporary Assistance to Needy Families (TANF) program are also eligible for Medicaid whether or not they actually receive TANF cash assistance.

Pregnant Women and Children. Pregnant women and children under age 19 with family incomes up to 150 percent of the federal poverty level are eligible for Medicaid. Prior to July 1, 1998, children age one through five were not eligible if their family incomes exceeded 133 percent of the federal poverty level and children age 6 through 18 were not eligible if their family incomes exceeded 100 percent of the federal poverty level. As of September 1, 1998, all Medicaid eligible children are entitled to twelve months continuous Medicaid coverage regardless of subsequent changes in family income. The income standard and continuous coverage changes were enacted in 1998 as "Phase I" of Indiana's implementation of the federal Children's Health Insurance Program (CHIP). In 1999, Governor O'Bannon signed into law the second phase of CHIP, which will begin January 1, 2000. The second phase of CHIP, *called Hoosier Healthwise Package C - Children's Health Plan*, is a non-Medicaid expansion of Hoosier Healthwise and will focus on children in families with income levels between 150 and 200 percent of the federal poverty level.

Aged. Individuals age 65 or older are eligible for Medicaid if they meet the financial criteria as described in the Medicaid Eligibility Overview Table on page 8. The financial criteria are more lenient if one spouse is in a nursing facility, while the other lives in the community. Persons eligible for Medicare Part A may qualify to have Medicaid pay their Medicare premiums, co-insurance and deductibles as a Qualified Medicare Beneficiary (QMB). In addition, a person categorized as a Specified Low-Income Medicare Beneficiary (SLMB), or a Qualified Individual-1 (QI-1) due to Medicare part A eligibility and income may qualify to have Medicaid pay their Medicare part B premiums. Medicaid will also pay a small portion of Medicare Part B premiums for a Qualified Indiviual-2 (QI-2), a Specified Low-Income Medicare Beneficiary (SLMB), a Qualified Individual (QI) or a Qualified Disabled and Working Individual.

Blind and Disabled. The definition of "blind" for eligibility purposes is the same as the definition used by the federal Social Security Administration. The definition states that an eligible person has vision 20/200 or less in the better eye with the use of correcting lenses, or with tunnel vision of 20 degrees or less, or who met the October 1972 State definition of blindness and received payments under the State's program of Aid to the Blind (AB) in December 1973. Furthermore, persons aged 65 or older who receive Supplemental Security Income (SSI) because they are blind are classified as blind

Medicaid Eligibility Overview [TABLE 3]

Category	Non-financial Criteria	Typical Family Unit	Monthly Income Limit for Typical Family Unit	Resource Limit	Coverage Type	Elibility Period
Low Income Families	Dependent Child in home	1 Adult, 1 Child	$229 (25% of FPL))	$1,000	Full	6 month review
Pregnant Women	Pregnant	1 Unborn Child, 1 Adult	$229 (25% of FPL)	$1,000	Full	Terminates 60 days after delivery
	Pregnant	1 Unborn Child, 2 Adults, 1 Child	$2,088 (150% of FPL)	No Limit	LImited to pregnancy related services	Terminates 60 days after delivery
Newborn Children	Newborn Child of a female Mediciad recipient	2 Adults, 2 Children	No Limit	No Limit	Full	Until Child turns age 1
Under age 19	Child under age 19	2 Adults, 2 Children	$2,088 (150% FPL)[2]	No limit	Full	Continuous for 12 months
Aged[3]	Age 65 or older	Married Couple, Individual	Couple $751, Individual $500 (Same as SSI Standards)	Couple $2,250 Individual $1,500	Full	Annual Review
Blind	Blind	Married Couple, Individual	Couple $751, Individual $500 (Same as SSI Standards)	Individual $1,500	Full	Annual Review
Disabled	Substantial & indefinite impairment	Married Couple, Individual	Couple $751, Individual $500 (Same as SSI Standards)	Couple $2,250 Individual $1,500	Full	Annual Review
Medicare Catastrophic Coverage Act of 1988 (MCCA)	One spouse in nursing facility, one spouse in the community	Married Couple	$1,383 plus a % of shelter expenses not to exceed $2,049 for spouse at home.	$16,392-$81,960	Full	Annual Review
Qualified Medicare Beneficiary (QMB)[4]	Eligible for Medicare Part A	Married Couple, Individual	Couple $922, Individual $687 (100% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare premiums, deductibles, co-insurance	Annual Review
Specified Low Income Medicare Beneficiary[4]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1,106, Individual $824 (120% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part B premium	Annual Review
Qualified Individual-1[4]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1,245, Individual $927 (135% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part B premium	Annual Review[5]
Qualified Individual-2[4]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1,613, Individual $1,202 (175% of FPL)	Couple $6,000 Individual $4,000	$2.23 monthly, paid end of year	Annual Review[5]
Qualified Disabled	Lost Medicare Part A due to Earnings	Married Couple, Individual	Couple $1,844, Individual $1,374 (200% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part A premium	Annual Review

[2]Effective July 1, 1998, children age 1-5 with income between 133% and 150% of the poverty level and children age 6-18 with income between 100% and 150% of the poverty level became eligible. This expansion was "Phase 1" of Indiana's Children Health Insurance Program (CHIP). Children under age 19 in all categories receive 12 months of continuous eligibilty without regard to changes in income or other circumstances.

[3]Income Levels January 1999 - December 1999

[4]Income Levels April 1999 - March 2000

[5]Applications are approved on a first come, first served basis, until federal allotment is expended.

rather than aged. Currently, to be eligible in the disability category, a person must have a physical or mental impairment, disease, or loss that appears reasonably certain to continue throughout the lifetime of the individual without significant improvement and that substantially impairs his/her ability to perform labor or to engage in a useful occupation. Effective January 1, 2001, the disability definition will be expanded to allow health care benefits to be available to individuals who have severe medical conditions that are expected to last for four years or more and prohibit the individuals from working. Blind and disabled recipients may also be eligible for the Medicare-related programs described above, if they are eligible for Medicare.

It is important to note that Indiana has the most restrictive disability eligibility standard in the country. It is one of only two states that follow a more restrictive medical eligibility definition than is required by the federal Social Security Administration, which determines eligibility for the Supplemental Security Income (SSI) and Retirement, Survivors, and Disability Insurance (RSDI) program. Further, Indiana is one of only twelve states that has financial criteria that are more restrictive.

What Services are Covered Under Indiana Medicaid?

State Medicaid programs are required to provide certain basic services to members in order to qualify for federal matching funds. In addition, states may also receive matching funds for a variety of optional services approved by the federal government. In SFY 1999, Indiana provided 30 of 34 possible optional programs, making the Indiana Medicaid program one of the most comprehensive in the country.

Mandatory Services:

- Early/periodic screening diagnosis & treatment for those under age 21
- Family planning services and supplies
- Inpatient hospital services
- Laboratory and x-ray services
- Nurse midwife services
- Nurse practitioners' services
- Nursing facility and home health services for those age 21 and over
- Outpatient hospital services
- Physicians' services and medical & surgical services of a dentist
- Rural health clinic and federally qualified health center services

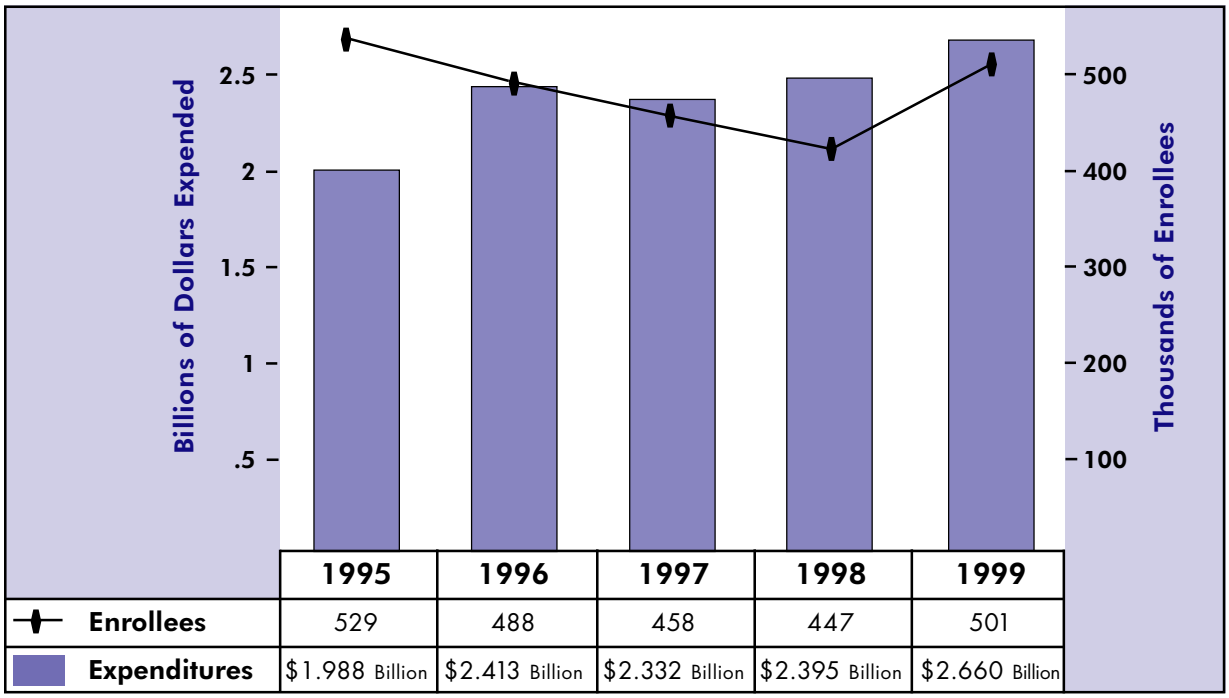
Optional services:

- Case management services
- Chiropractic services
- Christian Science nurse services
- Christian Science sanitariums
- Clinical services
- Dental services, including dentures and partials for adults
- Diagnosis services
- Emergency hospital services
- Eyeglasses
- Hospice care
- Inpatient hospital services for those above age 65 in institutions for mental diseases
- Inpatient psychiatric services for those under age 21
- Intermediate care for the mentally retarded
- Medical social worker services
- Nurse anesthetists' services
- Nursing facility services for those under age 21
- Occupational therapy
- Optometry services
- Physical therapy
- Podiatry services
- Prescribed drugs
- Preventive services
- Private duty nursing services
- Prosthetic devices
- Psychological services
- Rehabilitative services
- Respiratory care services
- Screening services
- Speech, hearing, and language disorder services
- Transportation services

What is the Cost of the Medicaid Program to Indiana?

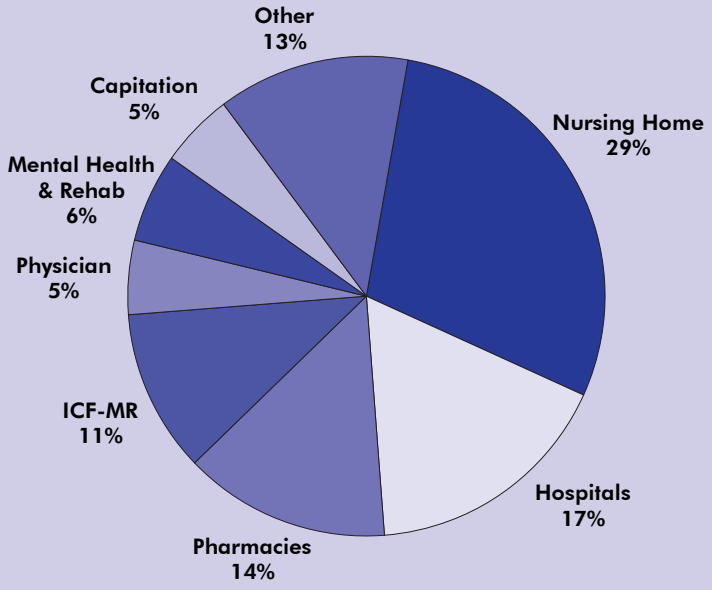
Medicaid Services. Medicaid is a major budgetary commitment for the State of Indiana, consuming approximately 12 percent of the state general fund budget in SFY 1999. In an effort to control rapidly escalating costs for services that more than doubled from SFY 1989 ($1.13 billion) to SFY 1993 ($2.32 billion), numerous cost containment initiatives were implemented beginning in SFY 1993. Those initiatives, combined with enrollment decreases resulting from welfare reform efforts, substantially reduced the growth in Medicaid services expenditures from

Medicaid Enrollees and Expenditures[6, 7, 8] [FIGURE 1]



	1995	1996	1997	1998	1999
Enrollees	529	488	458	447	501
Expenditures	$1.988 Billion	$2.413 Billion	$2.332 Billion	$2.395 Billion	$2.660 Billion

Medicaid Expenditures by Provider Category [FIGURE 2]



Provider Category	Expenditures (in Millions)
Nursing Home	$ 762
Hospitals[9]	465
Pharmacies	367
ICF-MR	297
Physician[10]	130
Mental Health & Rehab	150
Capitation	137
Other	352
Total	**$2,660**

[6]*Due to the implementation of a new Data Management and Analysis System in the fall of 1996, historical SFY figures previously published have been modified for consistency in reporting.*

[7]*Due to the implementation of the IndianaAIM claims processing system in February 1995, SFY 1995 expenditures are overstated. Based on an actuarial analysis of incurred (date-of-service) claims, the actual underlying rate of growth in expenditures in SFY 1995 was closer to -1% than to 13% and in SFY 1996 it was closer to 7% than to 20%.*

[8]*Enrollee counts refer to average monthly enrollment. Expenditures exclude DSH payments.*

[9]*Inpatient and outpatient services.*

[10]*Includes Physician PCCM Administrative Fee, General Practitioner, Family Practitioner, General Pediatrics, OB/GYN, General Internist, Specialist, Ambulatory Surgery Center and Medical Clinic.*

SFY 1994 through SFY 1998. However, From SFY 1998 to SFY 1999 expenditures and enrollees saw an 11 percent and 12 percent increase, respectively, largely due to the Medicaid expansion of healthcare services to children up to 150% of the FPL as of July 1, 1998.

The table below lists the number of recipients[11] and amount of expenditures by the Medicaid categories of service. Of the $2.66 billion Indiana Medicaid spent for services in SFY 1999:

- Acute care services accounted for about 55.3 percent, including capitation payments to managed care organizations.
- Long-term care services[12] accounted for 44.7 percent of expenditures. (Medicaid pays for approximately 68.3 percent of all nursing home residents in Indiana.)
- The federal and state shares were $1.63 billion and $1.03 billion, respectively.

Disproportionate Share Hospital Payments. When determining payments for inpatient hospital care, federal law requires state Medicaid programs to provide special consideration for hospitals that serve a disproportionate number of low-income patients. This requirement is referred to as the Medicaid disproportionate share hospital (DSH) payment adjustment. Indiana law provides for "Basic" and "Enhanced" DSH payments. The difference between these two types of DSH payments is the funding source of the non-federal share. For Basic DSH, the non-federal share is appropriated from state general funds for payments to acute care and private psychiatric hospitals, and from the state mental health fund for payments to state psychiatric hospitals. The non-federal share for Enhanced DSH

Expenditures and Recipients by Category of Service (expenditures are in dollars.)[13] [Table 4]

Medicaid Category of Service	Unduplicated Recipients	SFY 1999 Expenditures
Inpatient Services	97,078	388,698,460.00
Inpatient Psychiatric State	337	15,963,066.52
Inpatient Psychiatric Private	3,275	15,508,757.69
Outpatient Emergency	68,337	4,350,945.39
Outpatient Non-Emergency	80,733	4,287,522.20
Outpatient Non-Emergency Room	209,705	67,744,618.67
Capitated Services-Risk Based Premiums	205,003	137,065,977.99
Other Services	248,763	46,118,725.00
Physician PCCM Administrative Fee	903	6,515,641.66
Physician General Practitioner	38,934	4,736,971.93
Physician Family Practitioner	135,520	19,026,689.47
Physician General Pediatrics	68,031	12,034,444.66
Physician OB/GYN	39,349	13,579,511.10
Physician General Internist	48,027	7,431,568.68
Physician Specialist	211,508	50,118,483.10
Non-Physician Practitioner	36,961	6,788,750.37
Physician Ambulatory Surgery Center	1,790	316,086.57
Physician Medical Clinic	84,905	15,996,004.77
Legend Drugs	345,720	348,896,314.18
OTC Drugs	125,419	18,067,532.35
DME Supplies	72,903	46,454,934.41
Transportation Supplies	65,643	23,000,514.00
Nursing Home Services	52,526	761,534,124.09
ICF-MR Small Group	4,164	190,786,346.00
ICF-MR Larger Private	1,163	39,745,961.00
ICF-MR State	1,067	65,517,228.00
Home Health Services/Other	9,871	47,424,210.00
Mental Health Rehab Services	34,575	121,362,435.55
Other Mental Health Services	65,214	28,681,299.40
Dental Services	146,157	59,149,314.44
Chiropractic Services	8,005	2,050,574.46
Podiatrist Services	21,313	1,266,016.24
Optometric & Optician Services	93,272	10,327,689.62
Waiver Services	4,700	79,548,153.45
Total Expenditures		$2,660,094,872.96

[11] *"Recipient" refers to an enrollee for whom one or more Medicaid claims have been paid in a given year. A "recipient" also includes an enrollee for whom Indiana Medicaid has paid a monthly capitation payment, even if that enrollee does not receive a medical service.*

[12] *Long term care services include total institutional care, total community based waiver, home health and hospice.*

[13] *Categories of Service are as defined by Electronic Data Systems (EDS). Expenditures include State and Federal share. Source: DataProbe (1999)- includes line items for PCCM Physician Admin Fee and RBMC Capitation payments.*

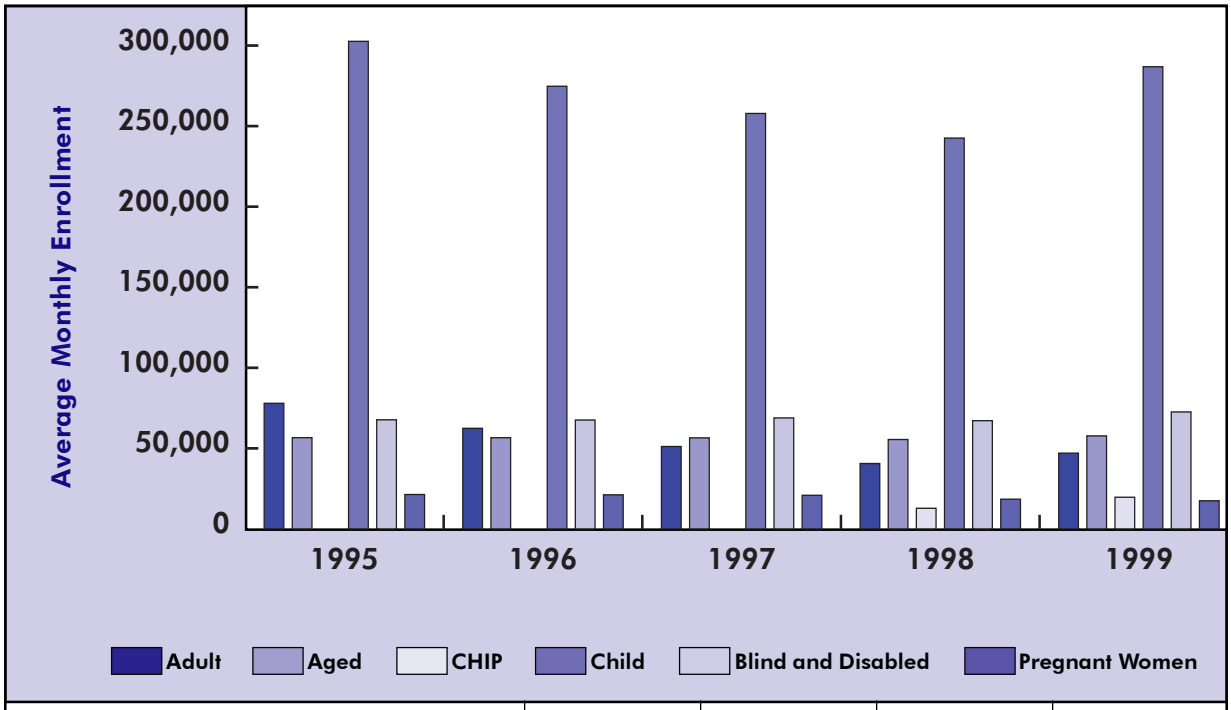
is provided through intergovernmental transfers from the Marion County Health and Hospital Corporation and from Indiana University. Enhanced DSH payments are made to acute care hospitals only.

Medicaid Administration. In addition to expenditures of $2.66 billion for health care services and $247.7 million for Basic DSH and Enhanced DSH payments, $134.3 million was expended in SFY 1999 to administer the Indiana Medicaid program. **Thus, 96 cents of every Medicaid dollar was used to fund direct health care services in SFY 1999.**

SFY 1999 DSH Payments [TABLE 5]

Basic DSH	
Small Acute	$8,000,000
Large Acute	$36,000,000[14]
Private Psychiatric	$3,170,393[15]
State Psychiatric	$94,286,650[16]
Enhanced DSH	$106,217,814
Total	**$247,674,857**

Medicaid Enrollees by Aid Group [FIGURE 3]



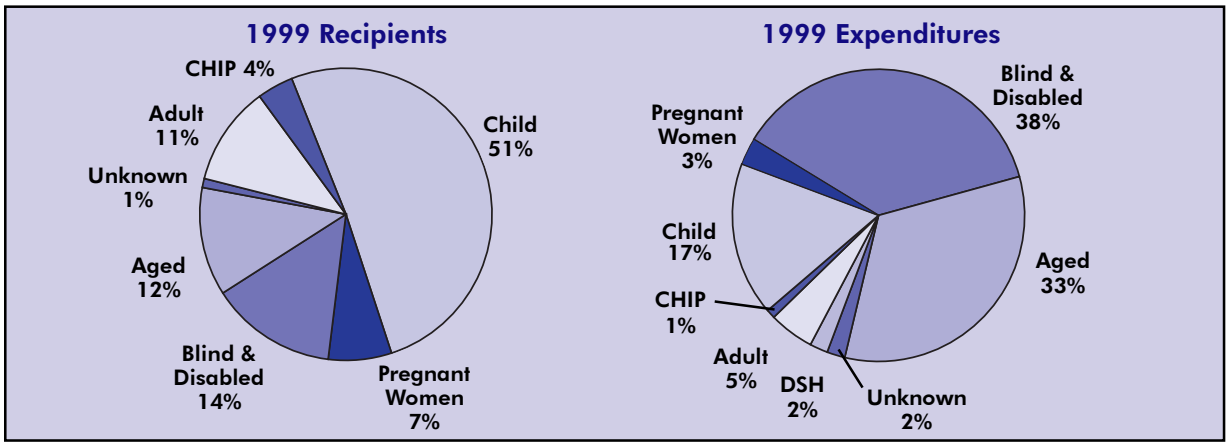
Aid Group	1995	1996	1997	1998	1999
Adult	77,966	62,447	51,163	40,594	47,044
Aged	56,647	56,613	56,521	55,495	57,752
CHIP	-	-	-	12,828	19,677
Child	302,599	274,722	257,851	242,560	286,839
Blind and Disabled	67,733	67,591	68,902	67,201	72,615
Pregnant Women	21,370	21,176	20,885	18,462	17,474
Total	**526,316**	**482,549**	**455,322**	**437,140**	**501,401**

[14]*In SFY 1999 DSH payments to large acute care hospitals were made for the past 2 years, $18 million/year.*

[15]*Basic DSH payments totaling $2 million payable to private psychiatric hospitals could not be made in SFY 1998 due to pending administrative appeals challenging the allocation methodology within the private psychiatric hospital Basic DSH pool. The total amount due to private psychiatric hospitals for SFY 1998 and SFY 1999 is $4 million. A partial payment of $3,170,393 was made in SFY 1999.*

[16]*Does not include partial payment for the 4th quarter of SFY 1999.*

[FIGURE 4]



Recipients

(Thousands)

	SFY 1995	SFY 1996	SFY 1997	SFY 1998	SFY 1999
Adult	94	91	72	63	66
Aged	67	73	73	71	72
CHIP[17]	-	-	-	-	22
Child	324	329	295	304	315
Blind and Disabled	71	75	76	77	83
Pregnant Women	36	45	45	48	45
Unknown	9	6	15	20	7
Total	**601**	**619**	**576**	**584**	**609**

Total Expenditures by Aid Group

(Millions of Dollars)

	SFY 1995[18]	SFY 1996	SFY 1997	SFY 1998	SFY 1999
Adult	145	157	127	106	130
Aged	714	804	790	805	891
CHIP[17]	-	-	-	-	16
Child	309	379	352	380	463
Blind and Disabled	737	919	925	970	1,032
Pregnant Women	59	98	88	85	80
Unknown	40	46	50	49	48
DSH[19]	28	25	28	23	47
Total	**$2,032**	**$2,428**	**$2,360**	**$2,418**	**$2,707**

Expenditures per Recipient by Aid Group

(Dollars per Recipient)

	SFY 1995	SFY 1996	SFY 1997	SFY 1998	SFY 1999
Adult	1,533	1,721	1,773	1,669	1,981
Aged	10,705	11,081	10,752	11,275	12,318
CHIP[17]	-	-	-	-	714
Child	940	1154	1,190	1,250	1,523
Blind and Disabled	10,403	12,278	12,229	12,586	12,439
Pregnant Women	1,622	2,158	1,961	1,762	1,807
Unknown	4,266	7,523	3,362	2,461	6,881
Total	**$3,384**	**$3,884**	**$4,048**	**$4,102**	**$4,367**

[17] *The CHIP category for SFY 1999 includes only the expenditures and receipts for children who became eligible for Medicaid as a result of the July 1, 1998 expansion. These data do not include children born before October 1, 1983 who receive the enhanced matched rate from the federal program.*

[18] *In SFY 1995, there was not a mechanism to quantify the capitation and administration payments per respective aid categories. In order to make SFY 1995 reporting consistent with SFYs 1996-99, the total capitation and administration payments were distributed among the adult (10%), child (75%), and pregnant women (15%) aid groups.*

[19] *"DSH Expenditures" reflect only Basic Disproportionate Share Hospital ("DSH") payments funded from the state General Fund and do not include (a)Basic DSH payments (excluding payments to state psychiatric hospitals) funded through the state Mental Health fund or (b)Enhanced DSH payments funded from intergovernmental transfers. DSH numbers are based on the reports from the office of financial management.*

How does Indiana's Medicaid Program Compare with Other States?

Medicaid Recipients as a Percent of Total State Population
Federal Fiscal Year 1998[20] [TABLE 6]

1.	Tennessee	33.95
2.	District Of Columbia	31.76
3.	Washington	24.84
4.	California	21.68
5.	Vermont	20.98
6.	New Mexico	18.97
7.	West Virginia	18.92
8.	Mississippi	17.65
9.	New York	16.91
10.	Arkansas	16.73
11.	Louisiana	16.49
12.	Kentucky	16.37
13.	Georgia	15.99
14.	Oregon	15.58
15.	South Carolina	15.51
16.	Rhode Island	15.49
17.	North Carolina	15.48
18.	Hawaii	15.47
19.	Massachusetts	14.77
20.	Michigan	13.88
21.	Maine	13.70
22.	Delaware	13.64
23.	Missouri	13.50
24.	Florida	12.77
25.	Nebraska	12.70
26.	Pennsylvania	12.69
27.	Alaska	12.13
28.	South Dakota	12.13
29.	Alabama	12.11
30.	Texas	11.77
31.	Connecticut	11.64
32.	Ohio	11.52
33.	Montana	11.44
34.	Minnesota	11.39
35.	Illinois	11.32
36.	Iowa	11.00
37.	Maryland	10.93
38.	Arizona	10.87
39.	Indiana	10.29
40.	Utah	10.28
41.	Oklahoma	10.23
42.	Idaho	10.03
43.	New Jersey	10.02
44.	Wisconsin	9.93
45.	North Dakota	9.76
46.	Virginia	9.62
47.	Wyoming	9.59
48.	Kansas	9.20
49.	Colorado	8.69
50.	New Hampshire	7.93
51.	Nevada	7.34
U.S. AVERAGE		**15.04**

Total Medicaid Per Capita Expenditures
Federal Fiscal Year 1998[20] (Amounts shown are dollars.) [TABLE 7]

1.	District Of Columbia	$1,397.93
2.	New York	1,336.90
3.	Rhode Island	930.07
4.	Massachusetts	749.84
5.	Connecticut	739.38
6.	West Virginia	686.39
7.	Minnesota	618.88
8.	Kentucky	616.10
9.	Maine	600.38
10.	Vermont	594.60
11.	Tennessee	583.21
12.	Delaware	564.46
13.	Ohio	546.05
14.	Louisiana	545.55
15.	Arkansas	542.01
16.	Alaska	538.07
17.	North Dakota	534.30
18.	North Carolina	531.90
19.	South Carolina	526.24
20.	Mississippi	524.10
21.	New Jersey	519.88
22.	Illinois	512.47
23.	New Hampshire	511.38
24.	Pennsylvania	506.62
25.	New Mexico	496.36
26.	Maryland	484.79
27.	South Dakota	482.05
28.	Missouri	472.49
29.	Nebraska	452.97
30.	Iowa	450.23
31.	Michigan	442.59
32.	Alabama	437.11
33.	California	435.82
34.	Indiana	434.64
35.	Hawaii	425.34
36.	Wisconsin	422.40
37.	Oregon	419.72
38.	Montana	410.29
39.	Wyoming	399.26
40.	Georgia	394.17
41.	Florida	381.26
42.	Colorado	362.47
43.	Texas	361.34
44.	Washington	359.31
45.	Arizona	352.13
46.	Oklahoma	351.94
47.	Kansas	348.54
48.	Idaho	345.50
49.	Virginia	311.90
50.	Utah	294.64
51.	Nevada	264.52
U.S. AVERAGE		**$526.52**

[20]*Population data from the U.S. Census Bureau. Expenditure and recipient information from the HCFA 2082 Report.*

Total Medicaid Expenditures Per Recipient for all Categories Federal Fiscal Year 1998[21] (Amounts shown are dollars.) [TABLE 8]

1.	New York	$7,906.51
2.	New Hampshire	6,448.91
3.	Connecticut	6,350.32
4.	Rhode Island	6,003.74
5.	North Dakota	5,475.52
6.	Minnesota	5,431.61
7.	New Jersey	5,187.60
8.	Massachusetts	5,075.06
9.	Ohio	4,742.08
10.	Illinois	4,526.04
11.	Maryland	4,436.55
12.	Alaska	4,434.13
13.	District Of Columbia	4,401.51
14.	Maine	4,382.52
15.	Wisconsin	4,254.57
16.	Indiana	4,222.02
17.	Colorado	4,173.09
18.	Wyoming	4,163.07
19.	Delaware	4,137.90
20.	Iowa	4,092.17
21.	Pennsylvania	3,991.93
22.	South Dakota	3,974.15
23.	Kansas	3,787.51
24.	Kentucky	3,763.16
25.	West Virginia	3,627.86
26.	Alabama	3,609.14
27.	Nevada	3,606.00
28.	Montana	3,585.14
29.	Nebraska	3,566.31
30.	Missouri	3,500.81
31.	Idaho	3,446.39
32.	Oklahoma	3,439.24
33.	North Carolina	3,436.68
34.	South Carolina	3,392.86
35.	Louisiana	3,307.60
36.	Virginia	3,242.63
37.	Arkansas	3,239.25
38.	Arizona	3,238.27
39.	Michigan	3,188.08
40.	Texas	3,071.19
41.	Florida	2,985.86
42.	Mississippi	2,969.27
43.	Utah	2,866.88
44.	Vermont	2,833.58
45.	Hawaii	2,748.62
46.	Oregon	2,694.82
47.	New Mexico	2,617.18
48.	Georgia	2,465.14
49.	California	2,010.20
50.	Tennessee	1,717.88
51.	Washington	1,446.52
U.S. AVERAGE		$3,501.10

As shown in the first table on page 14, Indiana ranks 39th among other states, with 10.3 percent of its state population enrolled in Medicaid. Indiana ranks 34th in expenditures per capita with approximately $435 per capita. The table to the left shows that Indiana ranks 16th in the total Medicaid expenditures per recipient, with $4,222 spent per Medicaid recipient in Federal FY 1999.[22]

Who is Utilizing Medicaid Services?

During SFY 1999, there were a total of 609,159 Medicaid recipients. "Recipient" refers to an enrollee for whom one or more Medicaid claims have been paid in a given year. A "recipient" also includes an enrollee for whom Indiana Medicaid has paid a monthly capitation payment, even if that enrollee did not receive a medical service.

As illustrated in Figure 4 on page 13, adults and children in low-income families make up approximately 62 percent of Medicaid recipients, but they account for only 26 percent of Medicaid spending. The aged, blind and disabled account for a majority of spending (70 percent), but only make up 26 percent of the recipients.

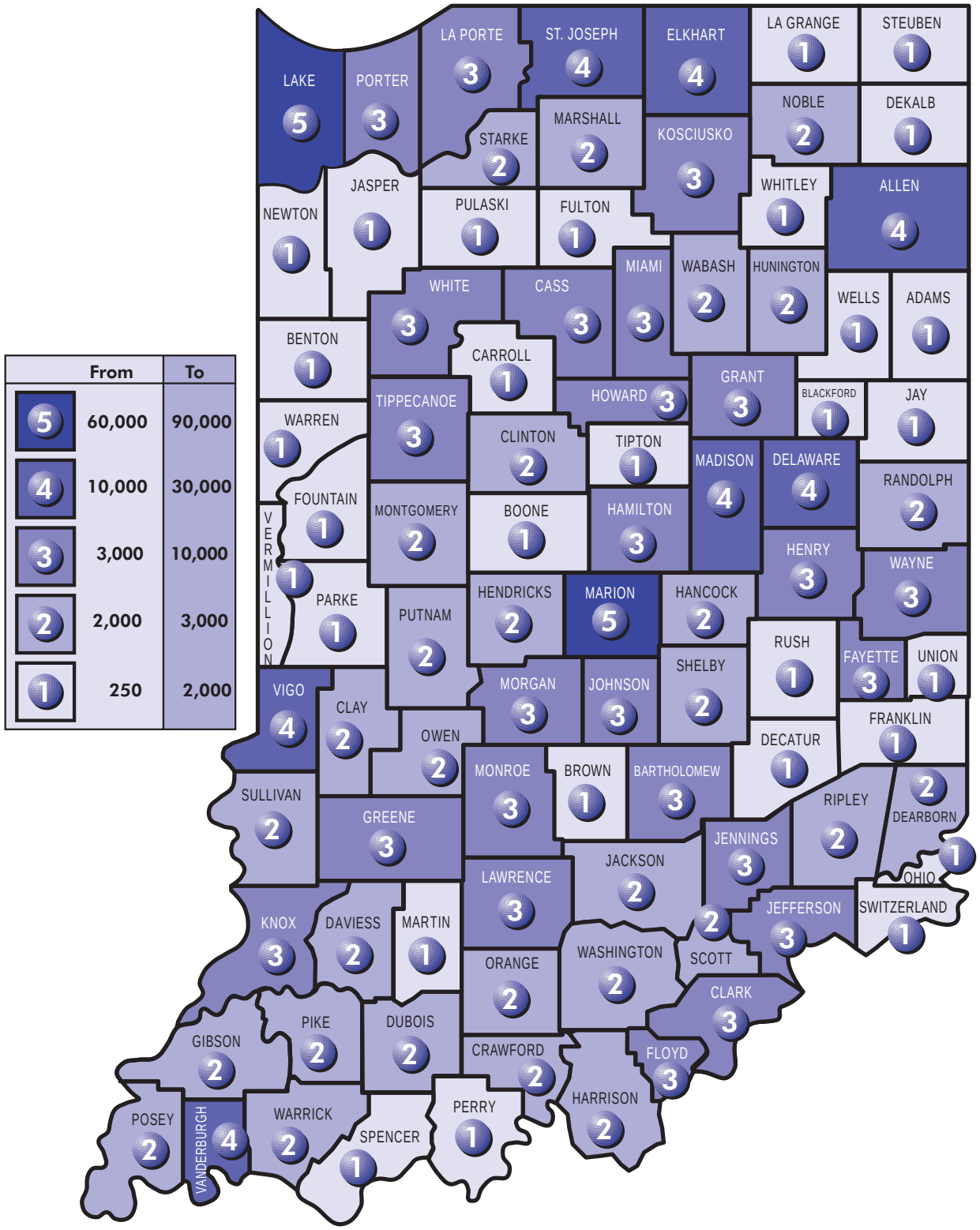
How has Medicaid Enrollment Changed?

The average monthly Medicaid enrollment during SFY 1999 was 501,401 members. The monthly average is a useful measure of Medicaid coverage because it takes into consideration the length of time that members remain eligible. The number of TANF adults, low income pregnant women, and children enrollees decreased in the mid 1990s due to welfare reform efforts and favorable economic conditions. In the late 1990s, the trend reversed through aggressive outreach and passage of the 1998 (Phase I) and 1999 (Phase II) CHIP legislation. As of June 1999, 85,310 additional children were enrolled to receive health care through Hoosier Healthwise. This is a 41 percent net increase in age 0-18 enrollment from May 1998. Average monthly enrollment in the aged, blind and disabled categories, which have the highest per recipient cost, have remained stable. These trends are illustrated in Figure 3 on page 12.

[21] *Population data from the U.S. Census Bureau. Expenditure and recipient information from the HCFA 208Z Report.*

[22] *The figure $4,222 is based on the Federal Fiscal Year (October 1-September 30), not the State Fiscal Year (July 1-June 30). The $4,222 in expenditures reported in FFY 1999 is the average of SFYs 1998 and 1999 reported in the "Expenditures per Recipient by Aid Group" table on page 13.*

SFY 1999 Average Monthly Enrollment by County [FIGURE 5]



Selected Program Summaries

Hoosier Healthwise Managed Care Program

Hoosier Healthwise is a health insurance program for Hoosier children, pregnant women, and low-income families. The program is offered through the State of Indiana's Family and Social Services Administration and is funded by Medicaid and CHIP. It has been operating since 1994, providing comprehensive health care services to Hoosiers at varying ages and varying income levels. The goals of Hoosier Healthwise are:

- ✓ To ensure access to primary and preventive care services.
- ✓ To improve access to all necessary health care services.
- ✓ To encourage quality, continuity and appropriateness of medical care.
- ✓ To provide medical coverage in a cost effective manner.

Hoosier Healthwise provides medical benefits designed to meet all of the health care needs of Hoosier Healthwise members, with a special focus on children's health care needs as they grow from infants to young adults. Benefits include primary and preventive care (such as well baby/well child care and regular check-ups), doctor visits, hospital stays, prescription drugs, vision and dental care, mental health care, and other important health care benefits.

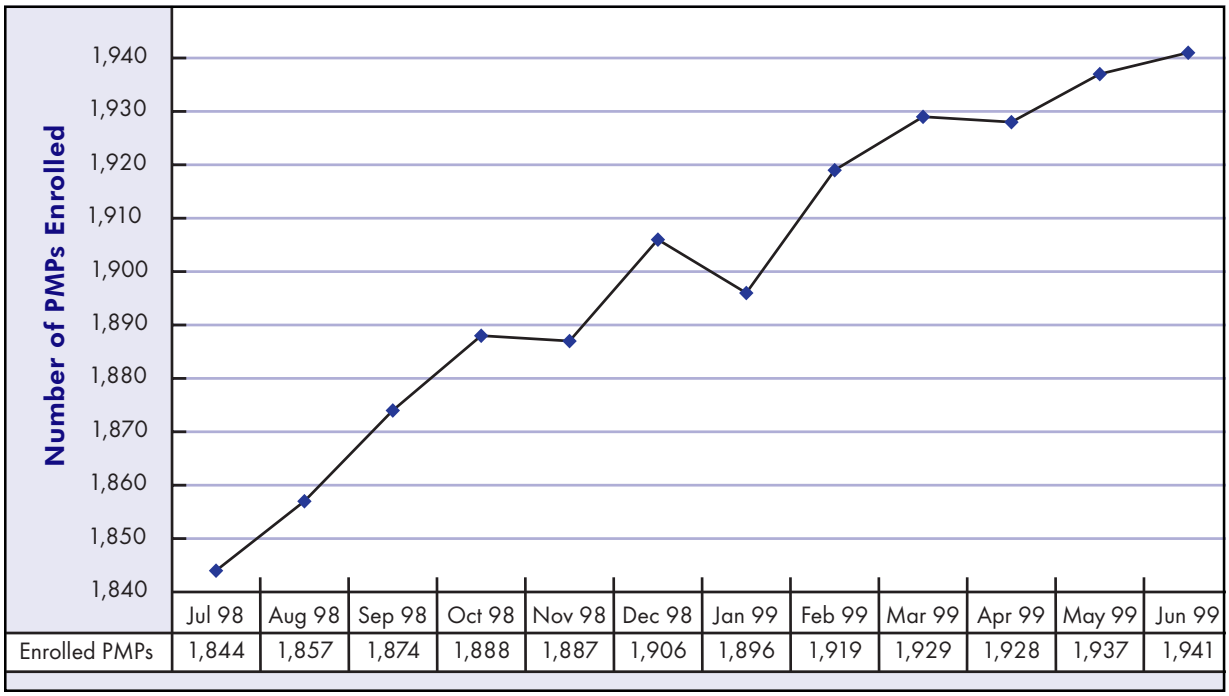
All children, from birth through age 18, are eligible for the Hoosier Healthwise program if their family meets the income guidelines. Adults eligible for the Hoosier Healthwise program include those receiving Temporary Assistance to Needy Families (TANF), including pregnant women with incomes at or just above the income guidelines.

Families can enroll in Hoosier Healthwise at their local Division of Family and Children (DFC) office or they can go to a conveniently located enrollment center, such as a hospital or community health center. In addition, families can also apply through the mail using the single page (2-sided) application form, mailing the completed application form back to the Hoosier Healthwise program. In SFY 1999, Hoosier Healthwise comprised 66 percent of total unduplicated Medicaid enrollees. As of June 1999, there were 330,000 individuals enrolled in Hoosier Healthwise.

PMP Linkage. Hoosier Healthwise is designed to enroll members into the program by linking them with a Primary Medical Provider (PMP). A PMP is a doctor who provides all basic medical services, and offers referrals to more specialized care providers. This linkage allows members to have continual access to a doctor who will provide primary and preventive care services, which increases the quality of care to the member while helping to control the cost to Medicaid.

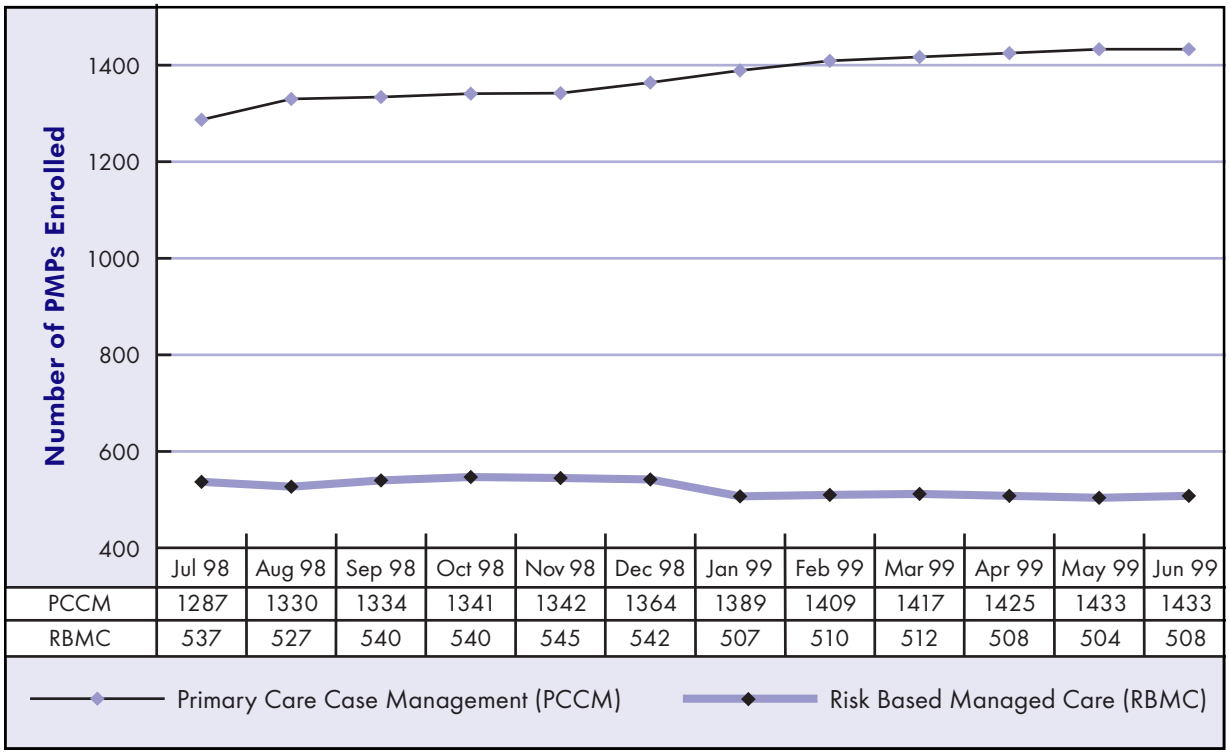
One of the unique features of Hoosier Healthwise is its focus on the relationship between the member and the PMP. Rather than choosing a health plan, members are asked to choose a PMP who is appropriate for their needs. If a member does not choose a PMP, a computerized auto-assignment process is initiated to try to link the member with an appropriate PMP. A PMP is able to determine his or her panel size, a number usually between 150 and 2000, which is the number of Hoosier Healthwise members the PMP is willing to accept as new and continuing patients. During SFY 1999, Hoosier Healthwise enrolled approximately 100 additional PMPs. There are now PMPs in all 92 counties.

FY 1999 Hoosier Healthwise Enrolled PMPs [FIGURE 6]



	Jul 98	Aug 98	Sep 98	Oct 98	Nov 98	Dec 98	Jan 99	Feb 99	Mar 99	Apr 99	May 99	Jun 99
Enrolled PMPs	1,844	1,857	1,874	1,888	1,887	1,906	1,896	1,919	1,929	1,928	1,937	1,941

FY 1999 PMP Enrollment by Delivery System [FIGURE 7]



	Jul 98	Aug 98	Sep 98	Oct 98	Nov 98	Dec 98	Jan 99	Feb 99	Mar 99	Apr 99	May 99	Jun 99
PCCM	1287	1330	1334	1341	1342	1364	1389	1409	1417	1425	1433	1433
RBMC	537	527	540	540	545	542	507	510	512	508	504	508

Delivery Systems and Health Plan Networks. The Hoosier Healthwise program is designed so members choose a primary medical provider (PMP) in one of two delivery systems:

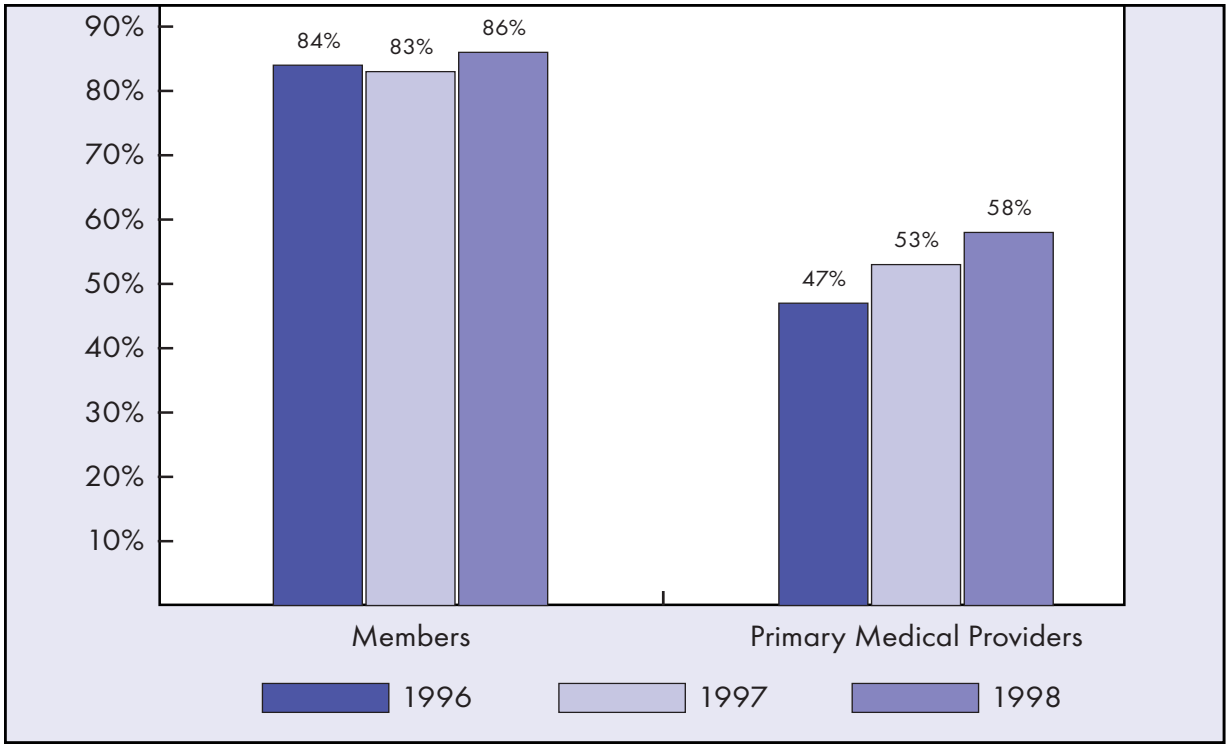
- Primary Care Case Management (PCCM). This plan network is referred to as PrimeStep.
- Risk-Based Management Care (RBMC). This delivery system is made up of Managed Care Organizations (MCOs). In SFY 1999, the plan networks were Managed Health Services (MHS) and MaxiHealth.

Contracted MCOs assume financial risk for developing and managing a health care delivery system that arranges for or provides Hoosier Healthwise covered services. The State pays the MCO a monthly capitation fee per enrolled member. PMPs within the PCCM delivery system are paid on a fee-for service basis, in addition to the monthly administrative fee of $3 per member per month. During SFY 1999, the PMP enrollment in RBMC has remained constant, while the enrollment in PCCM has increased approximately 10 percent.

Program Satisfaction. Surveys are conducted annually to assess the attitudes, behaviors and perceptions of enrolled Hoosier Healthwise members and PMPs. Results in SFY 1999 (1,505 members surveyed) indicated that 81 percent did not have health insurance before joining Hoosier Healthwise. Thirty-nine percent of the members surveyed did not have a physician relationship before joining, and 89 percent of the members surveyed stated they had visited their doctor within 6 months of the survey. Also, 81 percent considered their health status "very good" or "good" and 64 percent of the members surveyed considered their health status to be much better than before they enrolled in Hoosier Healthwise. Of those members surveyed, more than two-thirds gave a "very good" rating for physician courtesy, quality of care, appointment lead times and staff courtesy.

The PMP survey was completed by 792 providers. In the past years satisfaction ratings have steadily improved, but unfortunately 34 percent continue to be at least "somewhat dissatisfied" and only 58 percent "somewhat satisfied" with the program. Satisfaction has increased from 23 percent in SFY 1995 to 58 percent in SFY 1999. A majority (66 percent) of PMPs surveyed are comfortable with their Hoosier Healthwise patient load. Of the remaining PMPs,

Satisfaction with Hoosier Healthwise Program [FIGURE 8]



they split evenly in the number that would like to increase or decrease their patient loads. Also, 44 percent felt that being assigned patients who have established relationships with other physicians was a problem. (See *FY 1999 Highlights* section for further accomplishments of the Hoosier Healthwise Managed Care Program.)

Hoosier Healthwise for Persons with Disabilities and Chronic Illnesses (HHPD) Program ends. The Hoosier Healthwise for Persons with Disabilities and Chronic Illnesses (HHPD) program was developed for non-institutionalized Medicaid enrollees who were determined disabled by OMPP's Medical Review Team. HHPD was a voluntary managed care program that provided additional case management and a wellness plan for each enrollee. Member enrollment began in Marion County in June 1997, and the HHPD program ended December 31, 1999. Member enrollment was 159 members by the end of State Fiscal Year 1999. By December 31, 1999, all HHPD members (total enrollment of 222 members) were transitioned back to the Traditional Medicaid fee-for-service delivery system. The Center for Health Care Strategies, a national non-profit, nonpartisan resource center, will be conducting a retrospective evaluation of the HHPD program to help OMPP determine what steps to take next with this program.

Children's Health Insurance Program

In 1997, Congress passed the Children's Health Insurance Program (CHIP) as part of the Balanced Budget Act. The Act allotted money to each State to develop a program to expand health coverage to uninsured children. Indiana chose to implement CHIP through an expansion of the *Hoosier Healthwise Program*. Thus, in 1998 legislation was enacted (effective July 1, 1998) that increased Medicaid eligibility for all children up to 150 percent of the federal poverty level (about $25,000 for a family of four). In June 1999, approximately 29,000 children received Hoosier Healthwise coverage funded through CHIP. In 1999, a non-Medicaid expansion of Hoosier Healthwise was enacted ("Phase II" of CHIP implementation) to cover children in families with incomes between 150 and 200 percent of the federal poverty level effective January 1, 2000.

Long Term Care, Home Health and Hospice Services

In SFY 1999, long term care services[23] accounted for 44.7 percent ($1.2 billion) of the total Medicaid Program expenditures. Long term care services include traditional institutional care provided to Medicaid residents in nursing homes, intermediate care facilities for the mentally retarded (ICFs/MR) and group homes, as well as non-traditional care provided in community settings through the Medicaid home and community based services waiver program. Other services delivered through Indiana Medicaid's long-term care program include home health care to support the medical needs of individuals who continue to reside in the community and hospice services for persons who are terminally ill.

Despite recent expansions made in the Medicaid waiver programs, Indiana's long term care service delivery system continues to rely heavily on institutional care for its Medicaid members. Of Medicaid long term care recipients, 73.6 percent received care in either a nursing home, ICF/MR, or group home in SFY 1999, while only 8.1 percent of recipients received their long term care services through the Medicaid waiver programs.

OMPP continues to work with other state agencies, consumers and providers to develop a more expansive, yet cost-effective long term care service continuum that is more responsive to consumer needs. OMPP's long term care goals are:

- To develop a full continuum of services that are responsive to consumer demand and facilitate the concept of person-centered planning, where services are arranged to meet the individual's needs, rather than fitting individual needs into available services.
- To develop a sound service delivery system that is responsive to market forces and flexible enough to move with changes in consumer service selection. To the extent practicable, low-income citizens should have a full array of options available to them, such that the gap between service availability and quality for low and middle-income (private pay) residents is minimized. Payment for services to the low-income, frail and elderly should be competitive, in order to ensure access to quality care.

[23]*Long term care services include services provided by institutional care, community based waiver, home health and hospice.*

- Quality in care and service delivery should become standard, with all long-term care program policies thoughtfully coordinated so that they complement, rather than contradict, each other. Program indicators of quality must be carefully identified, researched, and monitored, so that aggressive quality assurance protocols become a routine and reliable administrative practice.
- With the success of Welfare Reform, Medicaid programs need to be "de-stigmatized," so that they become recognized more generally as health care for those truly in need. The only way to accomplish this paradigm shift is to make consumer and provider education paramount.

As responsible stewards of public funds, OMPP must take proactive steps to maximize the use of existing funds and to explore innovative ways to bring in new funding opportunities. The focus must be on meeting the needs of the whole population in need of services, rather than on developing programs for just a few.

Aged. In SFY 1999, Indiana served 56 percent of its aged Medicaid members in nursing homes, 6 percent in the community[24] and less than 1 percent (0.6%) in ICFs/MR and group homes.

A new nursing home reimbursement system, implemented in October 1998, was designed to correct undesirable policies of the past and to allocate payment according to the care and resource needs of the residents. This new reimbursement system, called "case mix," builds upon data collected by federally-required MDS (minimum data set) assessments, and provides a rich source of cost and resident data never before available. OMPP continues to work in collaboration with nursing home provider representatives to develop a comprehensive audit program designed to assure payment integrity, verify service delivery, and ensure provider record-keeping accuracy.

Another important change made in SFY 1999 included an increase in the personal needs allowance from $35 to $50 per month for persons who reside in institutions. Public Law 272-1999 allows persons who reside in institutions to retain $50 of their own income each month to buy personal items, such as shampoo, toothpaste, newspapers, magazines, hair styling items and other incidentals.

Medicaid Payments for Nursing Facility Patients [TABLE 9]

	Number of Unduplicated Nursing Facility Patients	Total Annual Nursing Facility Payments	Average Annual Payments Per Nursing Facility Patient	Total Medicaid Patient Days	Average Cost per Medicaid Patient Day	Average Length of Stay
SFY '96	48,390	$679,930,560	$13,904	10,889,381	$62	223 days
SFY '97	48,906	$697,944,997	$14,271	10,621,931	$66	217 days
SFY '98	47,792	$687,662,853	$14,389	11,007,144	$62	230 days
SFY '99	52,526	$761,534,124	$14,498	10,848,121	$70	207 days

Developmentally Disabled. In SFY 1999, of Indiana's 17,028 mentally retarded/developmentally disabled Medicaid members[25], 6.3 percent are served in state operated facilities, 6.8 percent receive care in ICFs/MR, and 24.5 percent in group homes.

Services for the mentally retarded/developmentally disabled continue to be evaluated through the 317 Task Force (Public Law 245-1997). State operated facilities continue to be downsized to facilitate the movement of more individuals into the least restrictive, most integrated settings possible. Consistent with the state's efforts to downsize the larger institutional settings, IFSSA also assisted in transitioning residents from three large private ICFs/MRs that closed. Persons were transitioned into the community through a person-centered planning approach that matches services and providers to personal needs and choices.

[24]*Community Services are defined as home health, waiver and hospice categories of service.*

[25]*This number combines members with DSM-IV diagnosis codes including mental retardation, pervasive developmental disorders and tic disorders.*

SFY 1999 Medicaid Payments for ICF/MR [TABLE 10]

	Number of Unduplicated Residents	Total Payments	Annual Cost Per Resident
Group Home ICF/MR	4,164	$190,786,346	$45,818
Large Private ICF/MR	1,163	$39,745,961	$34,175
State ICF/MR	1,067	$65,517,229	$61,403

Home Health Care Services. Other services delivered through Indiana Medicaid's long-term care program include home health care to support the medical needs of individuals who continue to reside in the community. Home health services provided by the Indiana Medicaid Program include skilled services provided by a registered nurse or a licensed practical nurse, home health aide services, and therapy services including physical, speech and occupational therapy and require prior authorization by the Office of Medicaid Policy and Planning.

Hospice Services. SFY 1999 also marked the first full-year of the Medicaid hospice program. The total annual cost of $19,506,178 served 1,131 people compared to 503 people served in SFY 1998. The average length of stay for Medicaid hospice recipients in SFY 1999 was 72 days.

Hospice providers are paid a per diem for hospice covered services rendered to the Medicaid hospice recipient. These covered services are delivered and reimbursed according to one of the four levels of hospice care: routine home hospice care, continuous home hospice care, inpatient respite hospice care, and general inpatient hospice care. Hospice services require authorization by the Office of Medicaid Policy and Planning.

System modifications to IndianaAIM (the Indiana Medicaid Program's claims processing system) for the Indiana hospice program were not completed until January 28, 1998. On that date, the system became operational to accommodate hospice authorizations and hospice claims billing. The systems modification to IndianaAIM and the slow submission of hospice authorization forms by hospice providers, as they became familiar with Medicaid program guidelines, explain the low number of unduplicated hospice recipients for SFY98.

Medicaid Payments for Home Health Care Services [TABLE 11]

	Number of Unduplicated Home Health Recipients	Total Annual Home Health Payments	Average Cost Per Home Health Resident
SFY 1995	9,752	$35,229,249	$3,620
SFY 1996	10,153	$41,494,875	$4,087
SFY 1997	11,175	$42,886,866	$3,838
SFY 1998	11,843	$46,214,170	$3,902
SFY 1999	9,694	$47,424,210	$4,892

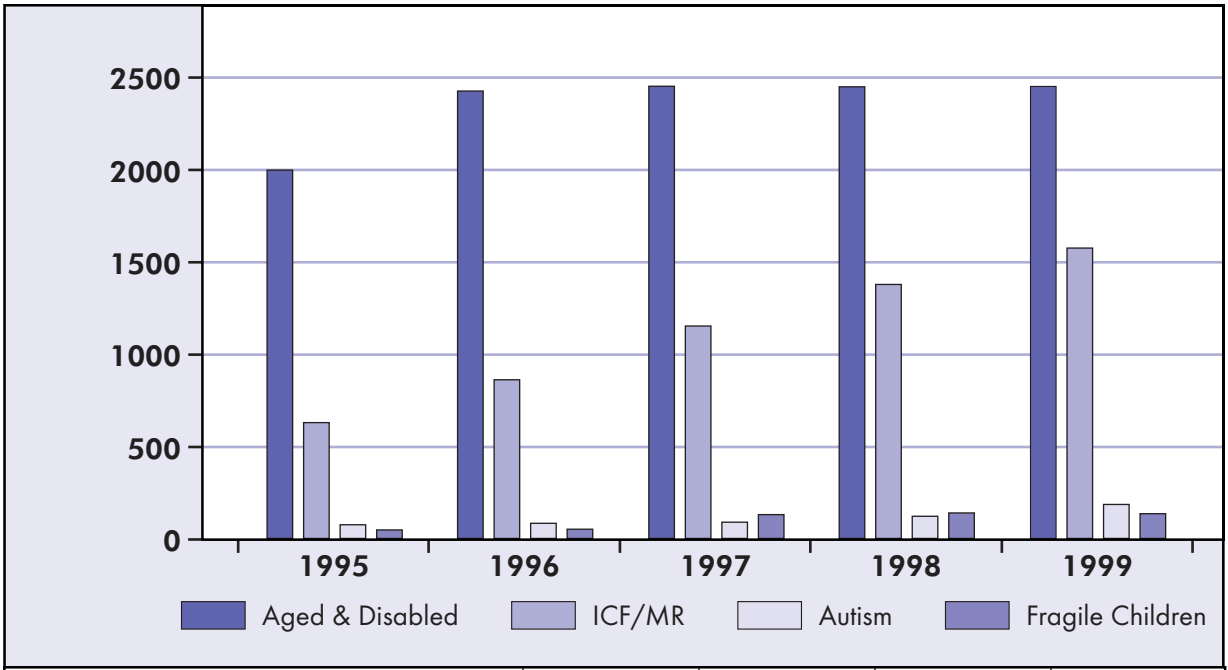
Medicaid Home and Community-Based Services Waiver Program. The goal of the Medicaid home and community based services waiver programs is to establish a framework that will assist states in identifying persons who are in need of institutionalization in the absence of the home and community-based services waiver program and other community supports. It also seeks to provide a cost-effective, flexible care plan for services to allow at-risk persons to remain in the community for as long as possible. Waiver placement options are available on a first-come, first-served basis and are limited to those who meet Medicaid eligibility requirements and are at risk of institutionalization. In essence, an individual must meet minimum nursing facility or ICF/MR level of care criteria to be eligible for the Medicaid home and community based services waiver program.

Indiana has four federally-approved, Medicaid home and community based services (HCBS) waiver programs. These include the Aged and Disabled Waiver, the Intermediate Care Facility for the Mentally Retarded (ICF/MR) Waiver, the Autism Waiver; and the Medically Fragile Children's Waiver. A fifth waiver program for persons with traumatic brain injury is was implemented on January 1, 2000.

The HCBS Waiver program includes the following services in addition to the services already available (e.g., physician, hospital, home health, etc.) to all Medicaid recipients:

- Case management
- Respite care
- Personal attendant care
- Homemaker services
- Home modifications
- Adaptive aids and devices
- Assistive technology
- Adult day care
- Home-delivered meals
- Residential-based habilitation
- Group and/or individual habilitation
- Supported employment
- Pre-vocational services
- Personal emergency response systems
- Family/caregiver training
- Supported living services behavior management
- Extended State Plan services of physical therapy
- Speech therapy
- Occupational therapy
- Transportation

Number of Waiver Recipients by Category [FIGURE 9]



Category	1995	1996	1997	1998	1999
Aged & Disabled	1,994	2,422	2,448	2,445	2,447
ICF/MR	627	859	1,150	1,375	1,572
Autism	74	82	88	120	184
Fragile Children	46	50	129	138	134
Total	**2,741**	**3,413**	**3,815**	**4,078**	**4,337**

Indiana Long Term Care Insurance Program

The Indiana Long Term Care Insurance Program, also known as the Indiana "Partnership Program," is a program administered by OMPP that encourages the sale and purchase of private long term care insurance by providing "Medicaid asset protection" to purchasers of qualifying policies. The program is a partnership among OMPP, the Indiana Department of Insurance and private long term care insurance companies. Indiana is one of only four states (along with California, Connecticut and New York) with such a program. The program was designed to:

- ✓ Provide incentives for the purchase of private long term care insurance,
- ✓ Allow Hoosiers to plan for their long term care needs without fear of impoverishment,
- ✓ Contain the growth of Medicaid expenditures for long term care by encouraging the purchase of private insurance,
- ✓ Improve the quality and affordability of long term care insurance policies while making them more affordable, and
- ✓ Increase public awareness of the costs, risks, and options relating to long term care.

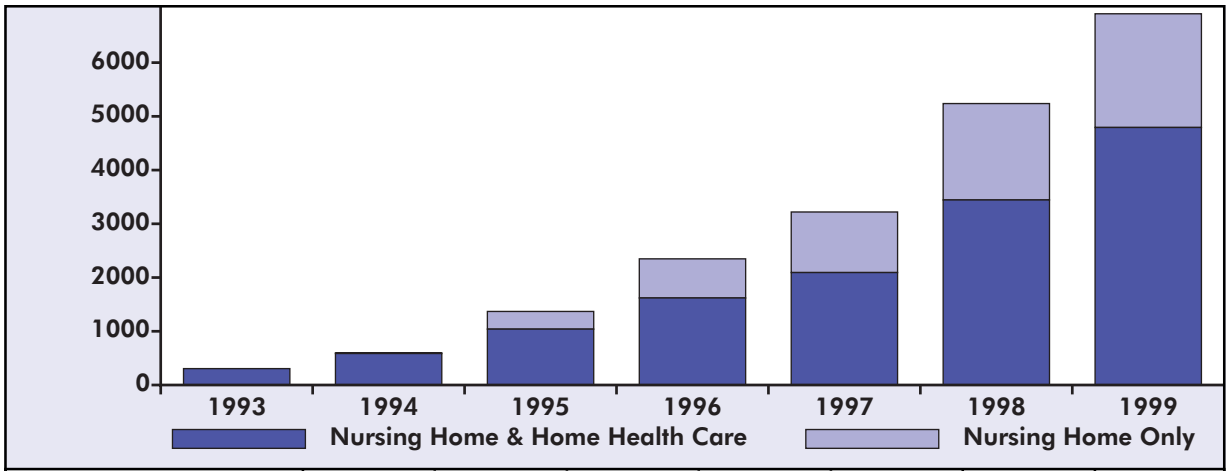
Legislation creating the partnership program passed the Indiana General Assembly in 1987. Federal approval was received in December 1991 and the availability of the first Partnership policies was announced on May 17, 1993. Through June 1999, 6,919 Partnership policies have been purchased.

In March 1998, the authorizing statute was amended expanding the asset protection feature by adding the option of unlimited asset protection. For a person to earn unlimited asset protection, he or she would first need to purchase a Partnership policy with a minimum initial coverage in the amount specified by the State. (This was $147,000 in 1999.) The State-set dollar amount increases each year and applies only to new policies purchased during that year. The policyholder would then need to exhaust the benefits of the policy. The amount of benefits exhausted must equal, at a minimum, the state-required minimum coverage amount specified for the year that the policy was purchased as inflated

Purchaser Information based on 6,919 policies purchased through June 30, 1999 [TABLE 12]

Female	**60%**
Married	**73%**
First-time purchasers	**87%**
Average age at purchase	**67 years**

Cumulative Number of Partnership Policies Purchased [FIGURE 10]

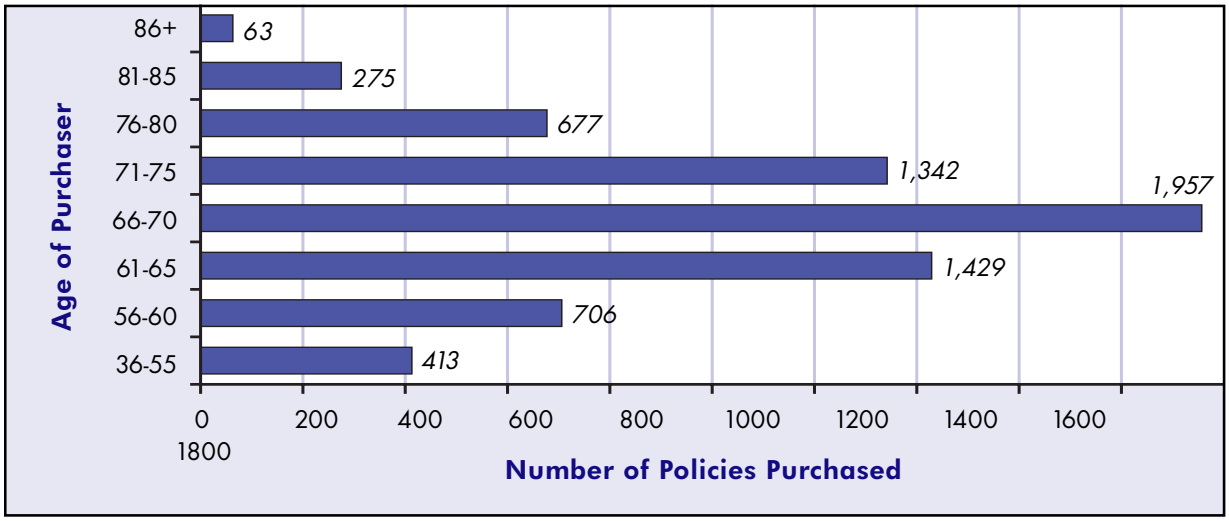


Type of Policy	1993	1994	1995	1996	1997	1998	1999
Nursing Home Only	0	12	329	728	1,127	1,794	2,116
Nursing Home & Home Health Care	305	586	1,040	1,620	2,093	3,444	4,793
Total	**305**	**598**	**1,369**	**2,348**	**3,220**	**5,238**	**6,909**

from the year of purchase at a 5 percent annual compounded rate. People who purchase Partnership policies that do not meet the criteria for unlimited asset protection will receive dollar-for-dollar asset protection. Dollar-for-dollar asset protection means that for every dollar of benefits paid out by the policy an equal dollar amount of asset protection is earned. All Partnership policies contain the consumer protections of standardized criteria for when the benefits will begin to be paid, as well as an inflation protection feature.

From the inception of the Partnership Program through June 30, 1999, twenty-nine policyholders have received policy benefits. Of these twenty-nine, four were receiving policy benefits as of June 30, 1999, six have died and approximately 88 percent have used the policy benefits for nursing home care.

Age Distribution of Partnership Policy Purchasers [FIGURE 11]



Third Party Liability

As a condition of eligibility for the Medicaid Program, every Medicaid member must legally assign their rights to any third party payment for medical expenses from any available resource to the Medicaid Program. Under federal and state law, OMPP is responsible for ensuring that Indiana Medicaid pays medical services only when there is no other source (third party) to pay for the member's healthcare. Third party resources include any entities, individuals, or programs that are legally responsible for paying the medical expenses of Medicaid members.

Cost Avoidance, Post Payment Recovery and Casualty Collections. Third party liability (TPL) recovery efforts occur both before and after payment of claims. IndianaAIM, the Medicaid claims processing system, maintains a record of insurance coverage per member. Through the use of system edits, if TPL resources are identified during claims processing, the claim will not pay unless the third party resource has been billed and the claim is submitted with evidence of third party payment or denial (referred to as "cost avoidance"). Post payment recovery activities (referred to as "pay and chase") center on invoicing health insurance companies for services initially paid by Medicaid. Post payment recovery is necessary when (a) federal law prevents the use of cost avoidance for certain services, or (b) the presence of health insurance coverage is detected after a claim for service is paid. In addition to the cost avoidance and post payment recovery, TPL recoveries also result from legal settlements of casualty cases. Each month a significant number of Medicaid members receive medical care as a result of injuries or accidents. Medicaid is responsible for pursuing recovery from liable third parties. These resources are also identified through IndianaAIM claims processing edits and through

referrals from outside entities such as insurance companies, providers, attorneys, and Medicaid members. TPL related savings for State Fiscal Years 1998 and 1999 are shown below.

SFY 1998 and 1999 TPL Savings[26] ($ are in millions) [TABLE 13]

	SFY 1998	SFY 1999
Post Payment Health Recoveries	$6.1	$14.8
Casualty Collections	$1.9	$1.5
Cost Avoidance		
Health Cost Avoidance	$43.5	$45.1
Medicare Cost Avoidance	$370.7	$354.5
Total Savings	**$422.2**	**$415.9**

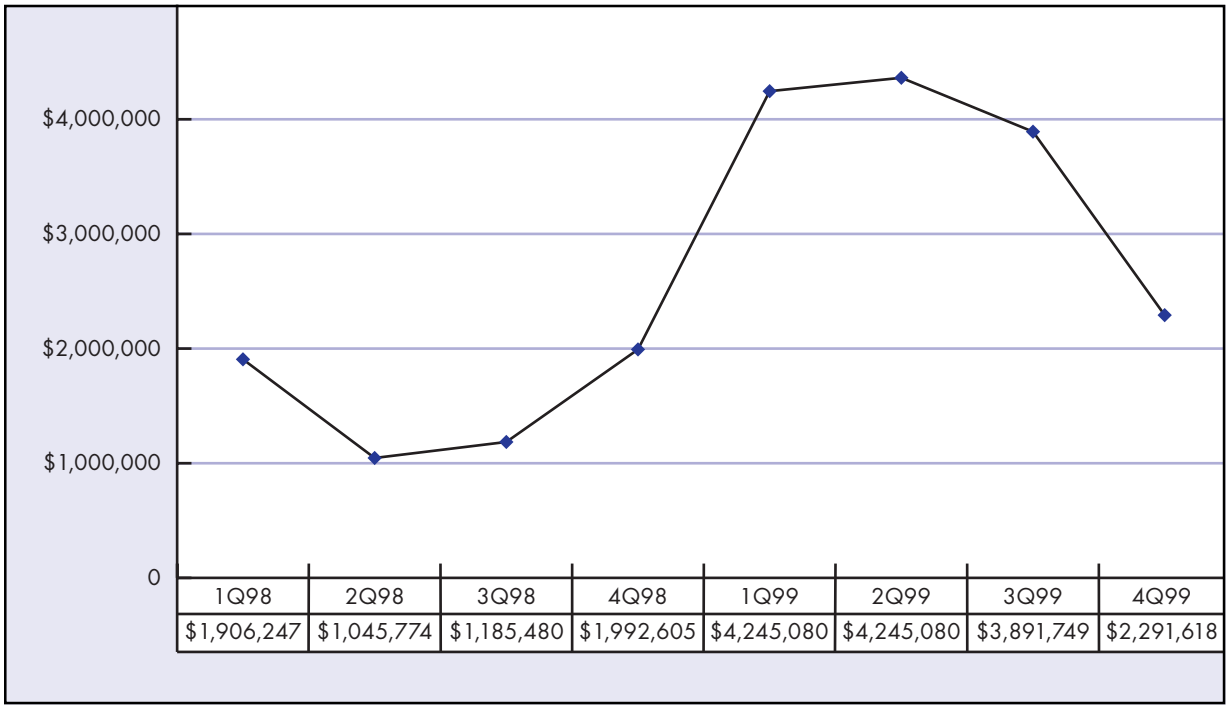
The TPL policies established by OMPP have saved Indiana taxpayers millions of dollars through cost avoidance, post payment recovery and casualty collection activities. OMPP contracts with Electronic Data Systems, Inc. (EDS) to perform the day-to-day TPL business functions. EDS subcontracts with Health Management Systems (HMS), a leading national TPL program contractor. HMS utilizes sophisticated data match software and techniques to increase post payment health recoveries. As demonstrated in the chart on page 27, post payment health recoveries increased dramatically beginning the first quarter of SFY 1999. Most of the increase (approximately $9 million) is attributable to a specialized Medicare project that involved identification of Medicaid members with Medicare eligibility previously unknown to OMPP, and post payment recovery of Medicaid payments that should have been paid by Medicare.

With regard to cost avoidance, an overall decline of approximately 3.5 percent was evidenced during SFY 1999. It is important to note that 89 percent of TPL savings from cost avoidance during SFY 1999 is attributable to Medicare health insurance coverage. The overall decline in cost avoidance for SFY 1999 was the result of an electronic crossover claim submission problem that was not corrected until the first quarter of SFY 2000. Crossover claims are claims that are paid by Medicare and then electronically crossover to Medicaid for payment of deductibles and coinsurance. For most of SFY 1999, as the result of a data-matching problem with Medicare, many claims failed to automatically crossover from Medicare to Medicaid for payment. During this time providers were required to submit their crossover claims to Medicaid on paper. As the Cost Avoidance chart on page 27 demonstrates, cost avoidance declined during the first quarter of SFY 1999 and gradually increased as providers became accustomed to the interim paper submission process. However, the paper crossover submission rate lagged behind the actual experience.

Federal law requires that state Medicaid agencies pay the Medicare premiums for members that are enrolled in both Medicaid and Medicare. The federal government pays one-half of the Medicare premium expense. During SFY 1999, the state share of Medicare premiums paid on behalf of Medicaid members totaled $24.2 million. Medicare cost avoided dollars for SFY 1999 totaled $354.5 million for a net saving to Medicaid (after Medicare premium payments) of $330.3 million for SFY 1999.

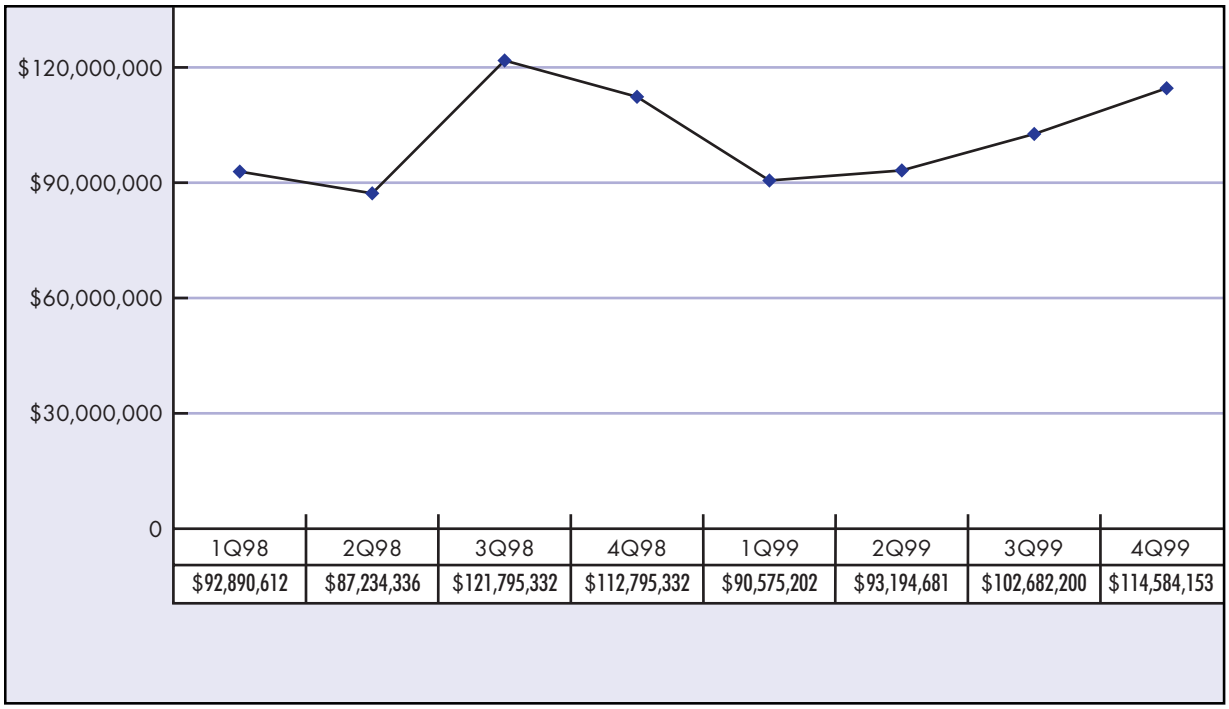
[26] *Data Source: OMPP TPL*

Post Payment Health Recoveries for State Fiscal Years 1998 & 1999[27] [FIGURE 12]



1Q98	2Q98	3Q98	4Q98	1Q99	2Q99	3Q99	4Q99
$1,906,247	$1,045,774	$1,185,480	$1,992,605	$4,245,080	$4,245,080	$3,891,749	$2,291,618

Cost Avoidance for State Fiscal Years 1998 & 1999[27, 28] [FIGURE 13]



1Q98	2Q98	3Q98	4Q98	1Q99	2Q99	3Q99	4Q99
$92,890,612	$87,234,336	$121,795,332	$112,795,332	$90,575,202	$93,194,681	$102,682,200	$114,584,153

[27] *Data Source: OMPP TPL*

[28] *The cost avoidance figures reported in the SFY 1998 Annual Report were overstated due to an incorrect reporting methodology. The cost avoidance figures for SFY 1998 as shown above are accurate.*

Estate Recovery

Indiana's Medicaid Program recovers the costs of medical care from the estates of Medicaid members who received services after the age of 55 years. According to the Office of Financial Enhancement, the state recovered in excess of $3.75 million from members' estates in SFY 1999.

Drug Rebate

The federal Omnibus Budget Reconciliation Act of 1990 (OBRA 90) established a requirement that, for drug manufacturers' products to be covered by State Medicaid programs, the individual manufacturers had to enter into rebate agreements with the federal government, acting on behalf of the individual states. Under this system, each state receives back from each rebating manufacturer a portion of the Medicaid funds expended by the state for the manufacturer's drug products.

Since the inception of the drug rebate program through SFY 1999, Indiana Medicaid has recaptured approximately $287 million. During SFY 1999, Indiana Medicaid realized $61 million in drug rebates proceeds. This represents a 26.8 percent increase over SFY 1998 proceeds of $48.1 million. While a portion of the increased drug rebate collections for SFY 1999 resulted from increased utilization, most of the increase was the result of heightened efforts to resolve outstanding disputes with manufacturers relative to the amounts identified as being owed to Medicaid.

Program Integrity

OMPP is responsible for monitoring both provider and member utilization of Medicaid services to ensure that the services rendered are necessary and in the optimum quality and quantity. Federal law also requires OMPP to have the ability to identify and refer cases of suspected fraud or abuse in the Medicaid program for investigation and/or prosecution, if warranted. Utilization review safeguards against unnecessary care and services and ensures that payments are appropriate according to the policies established by Indiana Medicaid relative to coverage, reimbursement and billing.

Organization and Goals. Indiana Medicaid has a variety of avenues for investigation of fraud and abuse. Within the fee-for-service and the Primary Care Case Management (PCCM) Program, activities are conducted by the Surveillance and Utilization Review (SUR) Unit of our medical policy contractor, Health Care Excel (HCE), OMPP's contractor for the SUR function effective January 1, 1999, and overseen by OMPP Program Operations staff. Review of providers who provide services to Risk Based Managed Care (RBMC) members is performed by the Managed Care Organization (MCO). The MCO(s) attend a monthly SUR meeting to discuss preventive and responsive strategies relative to Medicaid fraud and abuse. Review of the MCOs is addressed by OMPP staff working in the Hoosier Healthwise Program. Objectives of this area include:

- ✓ Development of statistical profiles of health care delivery and utilization patterns by providers and members in various categories of service.
- ✓ Monitoring utilization.
- ✓ Identification of abusive or suspected fraudulent practices of providers and members.
- ✓ Investigation and correction of inappropriate utilization of the Medicaid Program by individual providers and members.
- ✓ Identification of utilization trends and patterns to make recommendations for program changes.
- ✓ Identification of concerns in the level or quality of services provided to Medicaid members.
- ✓ Education and possible sanctions of members and providers found to have abused or inappropriately utilized services under Indiana Medicaid.

Referrals. The SUR Unit investigates reports of possible fraud and abuse for both providers and members that are received from a variety of sources, including state staff, other providers, officials, members, the public or county DFC Offices. HCE maintains a toll-free telephone line for reporting instances of possible fraud and abuse for investigation.

Utilization Review. Utilizing a computerized SUR reporting system, HCE generates individual provider and member statistical profiles. These profiles are used to identify cases requiring further review, which may include desk or field audits of provider medical records, claims and billing practices. Depending upon the audit findings, the HCE SUR Unit may take one or more of the following actions:

- ✓ Close the case if no aberrant practice is found.
- ✓ Provide appropriate education to correct minor infractions.

✓ Request repayment of improper reimbursements.

✓ Require manual pre-payment review of a provider's claims because of serious billing errors which show a consistent lack of knowledge of Medicaid rules, or a lack of desire to abide by these rules.

✓ Make a referral to the Indiana Medicaid Fraud Control Unit.

✓ Place a Medicaid member on a "restricted card program" in which payments for that member's care are limited to one primary physician, one pharmacy and one hospital, except for emergency or referral services.

The utilization review process also assists OMPP in making important policy decisions. For example, the utilization review activities may identify areas of policy that require clarification or change. It is therefore a valuable tool in shaping policy guidelines to ensure services are provided in an efficient and effective manner.

SFY 1998 and 1999 Utilization Review Statistics [TABLE 14]

	SFY 1998	SFY 1999
On-Site Audits	75	30
Dollars Recovered	$1,345,014	$4,346,519
Members on Restricted Card Status	130	186

During the first six months of SFY 1999, the State Utilization and Review Unit, in conjunction with FSSA legal staff, concentrated on closure of existing appeal cases; therefore, the number of on-site audits was less than usual and the amount of dollars recovered was greater.

Fraud Control. Allegations of Medicaid fraud and abuse are investigated by the Indiana Medicaid Fraud Control Unit (IMFCU) of the Indiana Attorney General's Office. During the IMFCU federal reporting year 1999 (case statistics from April 1, 1998 through March 31, 1999) the IMFCU generated $932,351.87 in recovered funds from fraudulent Medicaid billings. This amount includes restitution to the Medicaid program and funds returned to Medicaid members in cases involving the theft of patient personal funds.

Medicaid fraud takes many forms. In many cases, it occurs when medical providers double bill for services, provide services that are not medically necessary, bill for services which are not provided or miscode the diagnosis or procedure code in order to receive a higher level of reimbursement. The IMFCU has established a hotline to encourage people to report instances of fraud. Many investigative leads come through the hotline, mostly by employees, ex-employees or competitors of the provider in question. Other sources of information include the federal Medicare investigators, medical licensing boards, county offices, the SUR Unit, MCOs and other agencies in the health care fraud task forces. All referrals and leads are investigated by the IMFCU. Possible remedies include:

- Referring the case to county or federal prosecutors for criminal prosecution.
- Initiating a civil suit in state court or referring it to a civil United States Attorney to recover restitution, treble damages, fines and/or costs.
- Referring to an administrative agency to either take action against the provider's professional license or suspend participation in the Indiana Medicaid Program.

Often, the IMFCU pursues parallel criminal and civil cases and upon completion of the criminal case, refers the provider for administrative action.

Medicaid fraud recovery has benefited from greater interagency cooperation. Monthly meetings of the OMPP, IMFCU, the HCE SUR unit and representatives of Medicaid MCOs are held to coordinate activities and share information. The IMFCU is also a member of two health care fraud task forces, each of which includes representatives from the United States Attorney's Office, the Federal Bureau of Investigation, the Internal Revenue Service, postal inspectors, the Department of Health and Human Services, Office of Inspector General, Medicare and Medicaid fiscal intermediaries and managed care organizations.

SFY 1999 Medicaid Fraud Control Unit Statistics [TABLE 15]

7 convictions:	**$932,351.87 recovered**
5 for fraud	**310 cases pending**
1 for abuse	
1 for theft	

Drug Utilization Review

An important component of the Indiana Medicaid pharmacy benefit from both cost and quality of care perspective is what is known as drug utilization review (DUR). DUR is composed of two separate and distinct, yet complementary, components: prospective DUR (pro-DUR) and retrospective DUR (retro-DUR). With the point-of-sale (POS) claims submission process, each time a pharmacy provider submits an electronic claim to EDS, the pro-DUR system checks the paid claims history to see if the newly prescribed drug will in some fashion negatively interact with a medication that the patient may already be taking. The pro-DUR system alerts the pharmacist to any such possibilities, so that the pharmacist can initiate necessary action (e.g., contact the prescriber, discuss the matter with the patient, not dispense the drug, etc.).

Complementing the pro-DUR system is the retro-DUR functionality. This feature allows for analysis and review by the State's Medicaid Drug Utilization Review Board of patterns of prescribing and dispensing. In retro-DUR, paid pharmacy claims are periodically subjected to software that creates reports depicting how selected drug classes are being utilized. The Board subsequently reviews these aggregate level reports and determines whether or not educational interventions by the Board are warranted. The software also has the capability of generating intervention letters that, upon approval by the Board, can be sent to specific practitioners. These letters typically advise the practitioner of a detected prescribing pattern on the part of the practitioner that is not necessarily reflective of commonly accepted practice, suggests possible alternatives, and allows for a response should the prescriber choose to issue one.

Both pro-DUR and retro-DUR processes are educational in nature, and neither results in the denial of Medicaid claims nor attempts to dictate practice modes. They are designed to improve the quality of care for Medicaid members by virtue of providing information and to ensure that program funds are expended for services provided in accordance with commonly accepted standards of practice.

Prior Authorization

Organization and Purpose. OMPP contracts with Health Care Excel (HCE) to perform operational tasks associated with the prior authorization (PA) process. The PA process includes the review of prior authorization requests, which must be submitted by designated providers as specified by State regulation, and issuance of decisions surrounding those requests. The primary objective of prior authorization is to serve as a utilization management measure to allow payment only for those services that are medically necessary and covered by the Medicaid program. Although the prior authorization process certifies the medical necessity of services prior to Medicaid reimbursement, only covered services, which are those set out in the Medicaid medical policy regulations, may be reimbursed.

Duties. HCE reviews requests for authorizations in all categories of service in the Medicaid program, which are submitted via paper, telephone or fax transmission modes. Decisions must be entered into the IndianaAIM system within ten days of the request and receipt of all appropriate medical documentation. Information entered into IndianaAIM, which includes category of service, units requested, approved, denied or modified as well as dates received and entered, allow PA management staff to measure trends in decision-making as well as in the type of services requested. PA staff operates telephone lines and must meet contract requirements, continually measuring efficiency and customer service. On an average, approximately 21,000 PA requests are processed each month with the highest number of requests being in the areas of Durable Medical Equipment, Transportation, Home Health and Mental Health categories of service.

PA staff also perform administrative reviews of decisions with which providers disagree and prepare written responses to such requests. They prepare information for those cases that are heard by the Administrative Hearing and Appeals staff of FSSA. PA staff coordinate with other units at HCE as well as staff at EDS, regarding areas of medical policy, provider education, utilization trends or specific issues connected to the PA process.

Major Accomplishments of SFY 1999 for the Prior Authorization Unit include:

- ✓ Turnover of all PA materials and seamless transition of operations to HCE.
- ✓ Enhancement of internal operations management tools such as development of internal logs tracking requests returned to providers.
- ✓ Ongoing review and evaluation of customer service as measured by telephone reports, preparation of focus reports, contribution to provider educational materials.
- ✓ Development of a quality management process to monitor PA decisions, allowing HCE to identify and potential problems.

The PA Unit's goals for the year 2000 include efforts to continue improvements in procedures and processes with periodic evaluation relative to contractual requirements and provider satisfaction.

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